| Health Services  Walla Walla Public Schools  614 S. 3rd Ave.  Walla Walla, WA 99362 | | CHECK ONE:  ☐ Original Request  ☐ Extension  NOTE: Beginning date on extension requested must consecutively follow the ending date of original request. | | |
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| **STUDENT INFORMATION** | | | | |
| Student Name: (last, first, middle initial) PLEASE PRINT | | School Where Student is Enrolled | | Grade Level: |
| Student’s Parents/Guardian’s Name: | Telephone Number: | Enrolled in Special Education?  ☐ Yes ☐ No | Gender? | |
| **SECTION 1 - TO BE COMPLETED BY QUALIFIED MEDICAL PRACTITIONER** | | | | |
| DIAGNOSIS:  ☐ Disease/Injury/surgery (specify primary diagnosis) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ☐ Pregnancy (give due date)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ☐ Post-Partum (give delivery date)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ☐ Other (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   * **I certify that this student is physically unable to attend school because of their own medical condition for \_\_\_\_\_\_\_\_\_\_\_\_\_ weeks starting \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.** * **I certify that this student is physically unable to attend school because of their pregnancy starting \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and continuing for \_\_\_\_\_\_\_\_\_\_\_ weeks due to their medical condition.\*** * **I certify that this student is physically unable to attend school for \_\_\_\_\_\_\_ week’s post-partum due to their own medical condition.\***   \* Call school or tutor with delivery date. If delivery or recovery is complicated and more recovery time is needed, submit an extension for longer service. | | | | |
| Name of Provider: | Telephone number: | Business Address: | | |
| Signature: | Date: |
| **SECTION 2 - FOR SCHOOL DISTRICT USE** | | | | |
| Tutor’s name: | Telephone number: | School contact: | Position: | |
| Reviewed by: | Date: | Start date: \_\_\_\_\_\_\_\_\_  # of Weeks: \_\_\_\_\_\_\_\_ | ☐ Approved  ☐ Denied | |
| Questions? Call Health Services: 509-526-8507 | | | | |